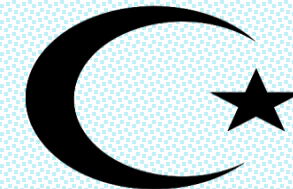
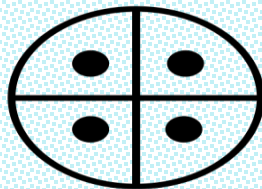


PTSD and Spirituality



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Disclaimer

The views expressed in this presentation are those of the author and do not necessarily reflect the official position or policy of the US Department of Veterans Affairs or Federal Government.

- You study *WHAT?*
- Do you actually call that science?



SECTION I: RELEVANT RESEARCH

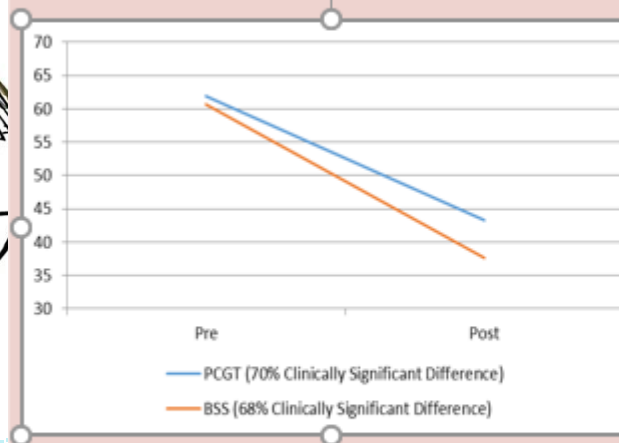


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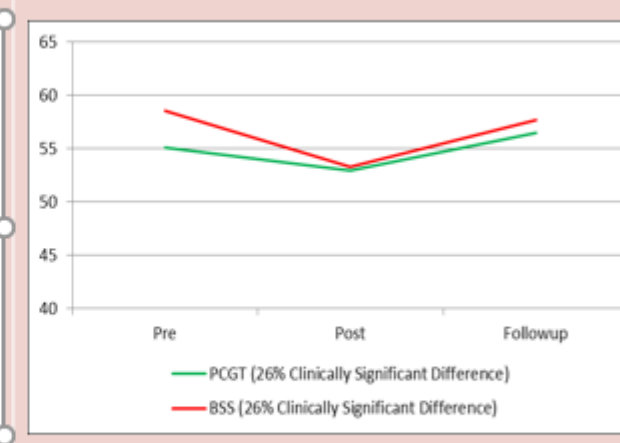
Figure 1: Changes in Spiritual Distress based on the Divine Distress scale of the Religious and Spiritual Struggle Scale

Clinician Administered PTSD Scale (CAPS)



$F[1,78] = 1.44, p = .23, \eta^2 = .02$

PTSD Checklist (PCL)



$t(\text{condition}) = 1.62, p = .107$
 $t(\text{time} \times \text{condition}) = -0.873, p = .384$



- Research documents a complex relationship between spirituality and recovery from trauma

Basic Spiritual Concepts

Spiritual Support

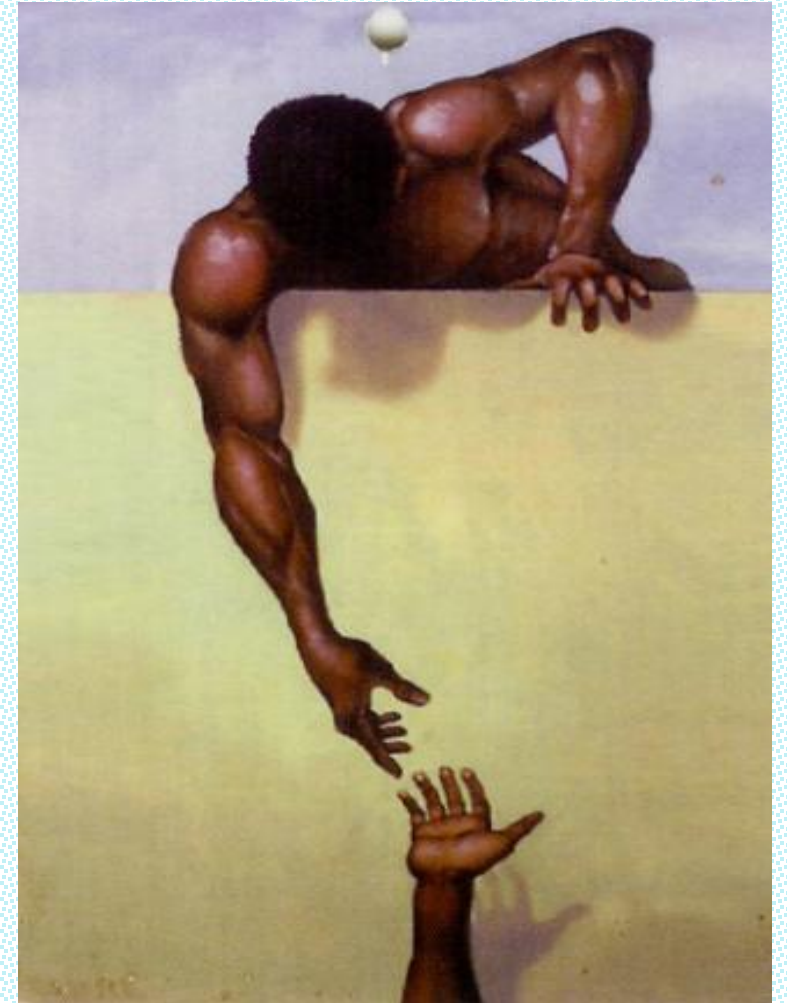
- Social support from community of faith
- Social support from perceived Higher Power
- Sense of meaning/purpose
- “Positive Religious Coping” or “Religious Comfort”

• Spiritual Distress

- Religious or spiritual fear/guilt/expectation of Divine punishment
- Disrupted relationship with Higher Power
- Negative experiences in community of faith
- “Negative Religious Coping” or “Religious Strain”

Spiritual Support

- Spiritual support is associated with greater posttraumatic growth (Harris et al., 2008).
- Spiritual support associated with more positive attitudes among trauma survivors (Ai et al, 2005).
- Social support from communities of faith only partially mediates relationships between spirituality and trauma outcomes (Harris et al., 2014)
- Effect sizes between spiritual support and PTSD are much smaller than those for relationships between PTSD and spiritual distress. (Park, Currier, Harris & Slattery 2017)



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Spiritual Distress

- More severe PTSD (Harris et al., 2008).
- Longer course/more difficulty benefitting from treatment (Currier et al., 2014;2015; Harris et al., 2012; Fontana & Rosenheck, 2004).
- Higher risk for suicide (Raines et al., 2017; Kopacz et al 2016).
- Is a component of moral injury (Drescher & Foy, 2008). (*More on this later!*)
- Mental health outcomes are poorer for those who lose faith in the context of trauma (Ben-Ezra et al., 2010; Fontana & Rosenheck, 2004, ter Kuile & Ehring, 2014).
- Preliminary findings suggest that spiritual distress impacts intimate relationships among trauma survivors (Harris et al., 2017; Sherman et al., 2018).
- In cross-lag designs, spiritual support predicts better treatment outcomes, spiritual distress predicts worse treatment outcome , and PTSD symptom severity does not predict future spiritual support or distress (Currier, Holland & Drescher, 2015). *Note etiological implications.*



Moral Injury



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- The psychological and behavioral sequelae of experiences that challenge deeply held moral, spiritual, or values related beliefs. (Litz et al., 2009; Jinkerson, 2016)
- Research on moral injury is still comparatively nascent; healthy debate continues about construct validity and definitions.

Signs of Moral Injury (Litz et al., 2009, Jinkerson, 2016)

- Loss of previously held spiritual beliefs
- Struggle or conflict in relationship with a Higher Power
- Difficulty forgiving self, others, or a Higher Power
- Feeling that there is no meaning or purpose in life
- Reduced trust in others
- Guilt and shame

Potentially Morally Injurious Events

I had to shoot him. When I searched his body, I found he was wearing a cross, and had pictures of a wife and 2 little kids....

He said he would only fill my requisition for medical supplies if I slept with him. People in my unit will die without those.

The crowd threw an infant in front of the convoy to stop us. I had orders not to stop.

I know whatever team I assigned to that position for this battle was likely to die.

They were all calling “Medic!” but I could not get to all of them. I had to let some of them die.

Circumstances that Can Precipitate Moral Injury (Litz et al., 2009)

Doing something that violates one's own moral code

Witnessing something that violates one's moral code, cherished values, or spiritual assumptions.

Feeling helpless to address a harmful situation

Betrayal by authorities or peers

Consequences of Moral Injury

As previously noted, these are early studies in a program of research that will extend far into the future. Only conclusions supported by multiple studies are presented here.

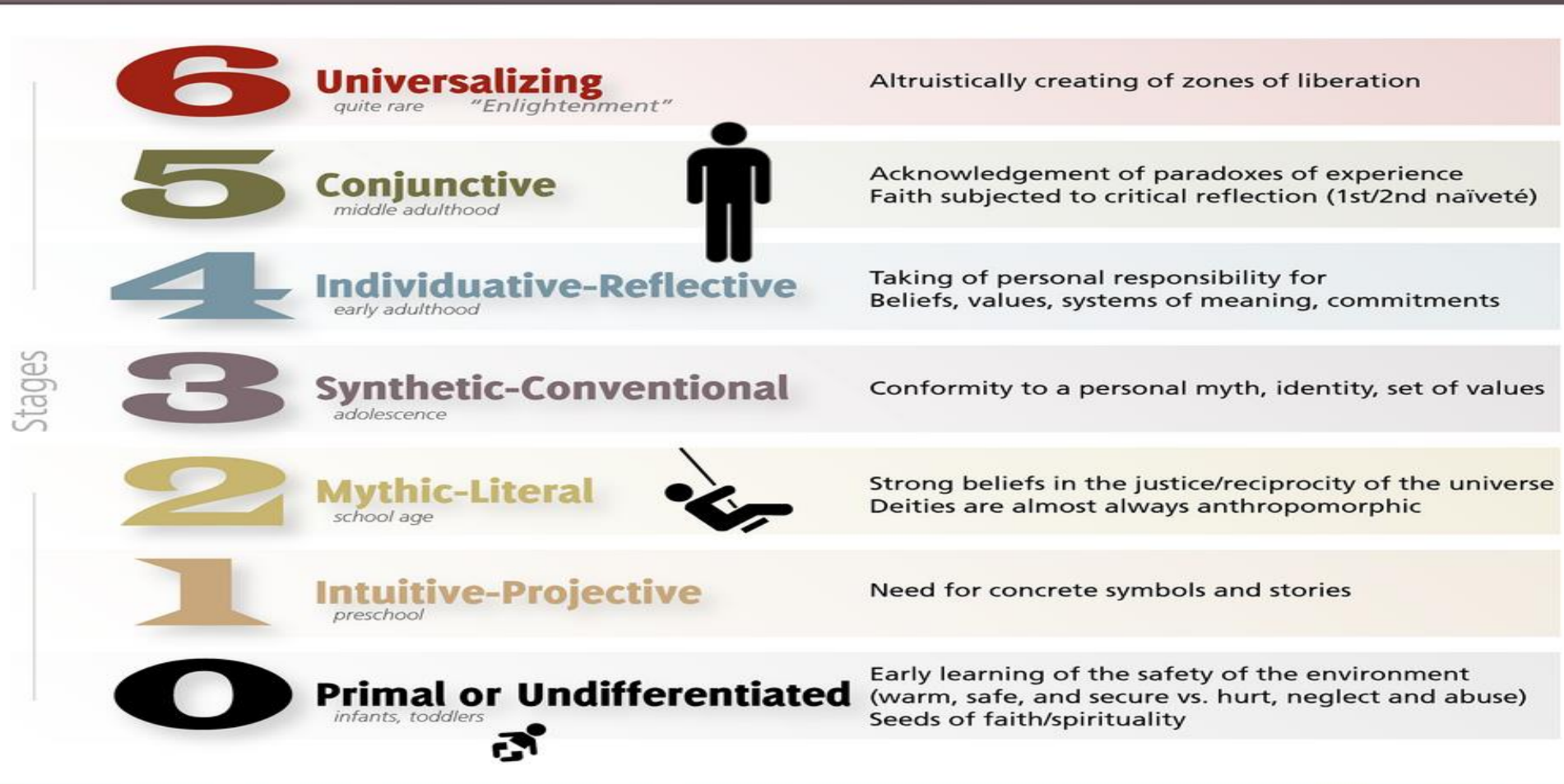
Increased risk for suicidal ideation and attempts (Bryan et al., 2014; Raines et al., 2017)

Reduced mental health resilience (Fontana & Rosenheck, 2004; Harris et al., 2012)

Loss of social support from community of faith, family and values-based activities (Glynn 2013; Harris et al., 2014)

Psychospiritual Development (Fowler 2006)

6 Stages of FAITH DEVELOPMENT



Developmental Expectations

(Harris et al., 2015;
Harris & Usset, 2018)

People are generally deployed ages 18-25

Most at those ages are functioning at
Fowler 2 or 3

Processing multiple moral contexts
requires at least an approach to Fowler
stage 4.

Our choices are to either grow or collapse

Dimensions of Moral Injury

Exposure vs. Developmental Etiologic Models

- Categorical vs. continuous conceptualization of moral dilemmas
- Judging one's young adult moral decision-making by older adult developmental standards

Internalizing vs. Externalizing Presentations

- Discriminate from antisocial functioning via temporal associations with exposure to moral injury

Realistic Guilt vs. Sense of Guilt

- A high percentage of those presenting in our lab are using sense of guilt as a terror management strategy; "If it was my fault, I had control of the situation."

SECTION II: SPIRITUALLY INTEGRATED INTERVENTIONS



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Levels of Spiritual Integration (Saunders et al. 2010)

- Spiritually Avoidant Care
- Spiritually Conscious Care
- Spiritually Integrated Care

Ethics Concerns (Currier, Kuhlman & Smith, 2015)

- Training and supervision for spiritually conscious and spiritually integrated care
 - Personal faith does not constitute training
- Ethical necessity of assessing and addressing spiritual concerns in trauma treatment
- Informed consent to spiritually integrated care
- Respecting client's faith identification
- Group settings: Inclusive and Personalized language
- Special concerns in public health settings
 - Proselytizing; educate group members
 - Spirituality/individual differences/culture in providers' ethics codes
 - Joint Commission requirements for spiritually sensitive care

Empirical Support for Spiritually Integrated Interventions for PTSD

- Building Spiritual Strength(BSS) (Harris et al., 2011; Harris et al., 2018)
- Mantram Repetition Program (MRP) (Bormann et al., 2012;2013;2018, Oman & Bormann, 2015)
- Adaptive Disclosure-Enhanced (AD)(new version including Compassion Training) (Litz et al. 2017; Gray et al., 2012)
- Impact of Killing in War(IOK) (Maguen et al., 2013;Maguen et al., 2017; (Purcell, Griffin, Burkman & Maguen, 2018)
- Compassion Meditation (CBCT-Vet)(Lang, 2017; Lang et al., in press)
- Lovingkindness Meditation (LKM) (Kearney et al, 2013;2014)
- Trauma Informed Guilt Reduction (TrIGR (Norman et al., 2014)

	Table 1: Spiritually Integrated Treatments for PTSD						
	BSS	MRP	AD-E	IOK	CBCT-Vet	LKM	TrIGR
Target population	All Veterans	All Veterans	Veterans/ Service Members	Those feeling responsible for deaths	All Veterans	All Veterans	Veterans describing distressing guilt
Intended use	Any time after symptoms onset	Any time after symptoms onset	Any time after symptoms onset	Continued symptoms after EVP	Any time after symptoms onset	Any time after symptoms onset	Any time after symptoms onset
Modality	Group	Group or Individual	Individual	Individual	Group	Group	Individual
Provider	Chaplains or Mental health providers	Mental health providers	Unspecified in manual	Mental health providers	Mental health providers	Mental health providers	Mental health providers
Setting	Community or Mental health	Mental health	Unspecified in manual	Mental health	Mental Health	Mental health	Mental health
Spiritual integration	Explicit	Explicit	Implicit	Explicit	Implicit	Explicit	Implicit

Building Spiritual Strength

- 8 group sessions
- Designed for trauma survivors who would like a spiritual dimension to their care
- One pilot randomized trial (Harris et al., 2011), N = 56
- One larger randomized trial (Harris et al., 2018), N = 138
 - BSS participation is associated with reduction in PTSD symptoms
 - BSS appears to be somewhat more effective for minority (African-American and Latinx) veterans.
 - BSS participation is associated with reduced spiritual distress, while those in an active control group reported increased spiritual distress.

Mantram Repetition Program

- 8 group sessions
- Used for many conditions
- Two randomized clinical trials for use with PTSD (MRP vs . case management) (Bormannet al., 2012;2013;2018, Oman& Bormann, 2015)
- Evidence of improved PTSD symptoms, spiritual well-being, self-efficacy, depression, insomnia, and satisfaction with physical health.

Adaptive Disclosure /Adaptive Disclosure Enhanced

- Initially 8 session, new version is 12 sessions
- Individual
- In a single-arm pilot trial, active duty Service Members who received individual Adaptive Disclosure services evidenced reduced symptoms of PTSD and depression, as well as increased posttraumatic growth. (Litz et al. 2017; Gray et al., 2012) This version of the intervention was not the spiritually integrated version.
- Adaptive Disclosure-Enhanced is currently in a multi-site randomized clinical trial, and has been augmented to include training in Compassion Training (secularized Lovingkindness meditation) to increase compassion toward self and others.

Impact of Killing in War

- 8-10 individual sessions
- Used for people who have completed an EBT for PTSD, but still have symptoms, and feel responsible for deaths in combat
- Focus of intervention is on self-forgiveness and making amends (Purcell, Griffin, Burkman & Maguen, 2018)
- One pilot randomized controlled trial published (Maguen et al., 2017)
 - N = 33
 - Significant changes in PTSD Sx, general psychiatric symptoms, and quality of life

Compassion Meditation

- Based on Buddhist principles but secularized
- 10 group sessions
- One nonrandomized, one randomized clinical trial (Lang, 2017; Lang et al., in press)
- Evidence of reduced PTSD symptoms and depression in randomized trial
- Preliminary evidence of increased social connectedness, empathy and mindfulness as well as decreased rumination

Lovingkindness Meditation

- Buddhist practice that may be construed as religious or nonreligious
- 12 group sessions
- One open pilot trial, comparing endpoints to baseline
- Although this data is without a control group, from endpoint to baseline there were improvements in PTSD symptoms
- Also observed increases in pleasant emotions, environmental mastery, personal growth, self-acceptance, and decentering

Trauma Informed Guilt Reduction Therapy

- Values-activation cognitive therapy
- 4 modules, 4-7 individual sessions
- One open pilot trial, comparing endpoints to baseline
- Although this data is without a control group, from endpoint to baseline there were improvements in trauma related guilt, which were correlated with improvements in PTSD and depressive symptoms

SECTION III: WORKING WITH CLERGY



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Scope of Practice

Chaplains

Nature of Higher Power
Scripture
Consistency of beliefs with stated affiliation
Use of self-disclosure

Licensed Mental Health Providers

Impact of anxiety/depression on perceptions of relationships
This includes the relationship with a Higher Power
Education about PTSD/depression/psychopathology
Different ideas about self-disclosure than we see in chaplaincy culture

Case Example



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- “Devin” is a 32-year-old Caucasian veteran receiving both Prolonged Exposure and Dialectical Behavior Therapy.
- He had questions about the consistency of mindfulness meditation with identification as a Pagan worshipper of the Norse gods.

Do Clergy Want to Work With Me?

- Short story, “Yes.” Most clergy actually would like to be consulted more frequently by their congregants’ therapists. (McMinn, Ammons et al., 2005; McMinn, Runner et al., 2005)



- But I'm not religious so I can't work with clergy...



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- Most clergy are not concerned that mental health providers' faith is not the same as their congregants. Their concerns are:
 - An effective ongoing relationship with the provider
 - Use of a spiritually conscious approach. (McMinn, Ammons et al., 2005; McMinn, Runner et al., 2005)

Why Should I Involve Clergy?

- Clergy have expertise in the client's specific faith.
- In many cases clergy will have long-term contact with the client and their family in community.
- Most mental health providers receive little training in providing spiritually conscious care.
(Hage et al., 2006)

COPE Model for Collaboration with Clergy (Milstein et al., 20008)

- Clergy Outreach and Professional Engagement
- Focused on *reducing burden* for both mental health providers and clergy

SUMMARY

- Recovery from trauma is related to both spiritual support and spiritual distress.
- Spiritually conscious care is a minimal ethical requirement.
- There is empirical support for some models of spiritually integrated care.
- Collaboration with clergy is possible and can be helpful.

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